Federally-Supported Health Centers Assistance Act of 1992 Amendments of 1995 (Pub.L. 104-73)

QUESTIONS & ANSWERS

1. Q: What is the purpose of the Federally Supported Health Centers Assistance Act of 1992 (ACT)?

   A: The purpose of the Act is to provide malpractice coverage to PHS-supported Community/Migrant Health Centers (Section 329/330), Health Care for the Homeless (Section 340), and Health Services for Residents of Public Housing (Section 340) programs and by eliminating or decreasing the need for private malpractice policies any savings realized may be utilized for the provision of services at the health center.

2. Q: What is the status of the Act since there was a sunset provision for December 31, 1995?

   A: Amendments to the Act were signed into law by President Clinton on December 26, 1995. The new legislation (Federally-Supported Health Centers Assistance Act of 1995, P.L. 104-73) made FTCA coverage for health centers permanent and has a provision which allows a grantee to choose whether to participate in the program.

3. Q: How can I get a copy of the new FTCA amendments (P.L. 104-73)?
   A: A copy of the new FTCA amendments is available on ACCESS, the BPHC computer bulletin board. The number is: 1-800-596-6405

4. Q: Who is eligible for FTCA coverage?

   A: The deemed grantee entity as well as its board members, officers, employees, full-time contractors, and certain part-time contractors are eligible.

5. Q: Which part-time contractors are eligible for FTCA coverage?

   A: The new legislation extends coverage eligibility of part-time contractors who normally work on average less than 32 1/2 hours per week to include licensed or certified providers in the fields of general internal medicine, family practice, and pediatrics services in addition to obstetrical and gynecological services. The types of providers covered would include nurse practitioners, physician's assistants, and certified nurse midwives, in addition to physicians.

6. Q: Are part-time (less than 32 1/2 hour/week) dentists who are employees covered by FTCA?

   A: Yes. All employees are eligibile for coverage under FTCA.

7. Q: If a deemed health center adds new staff, must it notify BPHC of these new employees in order for them to be covered by FTCA?

   A: No. Once a health center is deemed, FTCA coverage is conveyed automatically to their officers, board members, employees, and eligible contractors. FTCA coverage would begin on the date of employment.

8. Q: What documentation does a health center need to have on record for contractors or employees that are covered under FTCA?

   A: Both contractors and employees should have a clear written work agreement that describes the scope of services provided as part of their official duties and copies of their current licensure or certification in their profession. In addition, the FTE or working hours per week should be recorded for contractors since certain part-time contractors are not eligible for coverage.

9. Q: What activities are eligible for coverage?

   A: Medical, surgical, dental, and related activities are eligible for coverage if they are within the scope of the covered individual's employment and the grantee's approved Federal project as specified in their grant

application.

10. Q: Some health center physicians have shared call arrangements with community physicians to allow for 24-hour coverage for health center patients. These physicians must occasionally accept call or attend patients of the community physicians. Are these services eligible for FTCA coverage?

    A: Yes. Such services would be covered because they facilitate the provision or services to patients or the entity. The PHS published regulations on May 8, 1995 which clarified the eligibility for such activities as long as participation in this type of coverage arrangement is required by the health center and documented as part of the employment agreement or contract of the physician. The new amendments incorporates provisions of this regulation into law.

11. Q: In order to obtain hospital privileges at the local hospital, health center physicians are often required to provide coverage of the hospital emergency room or participate in hospital call for unassigned patients.

    A: Yes. The PHS published regulations on May 8, 1995, which clarified that such services are covered as long as obtaining hospital privileges is required by the health center and documented as part of the employment agreement or contract of the physician. The new amendments incorporates provisions of this regulation into law.

12. Q: If physicians employed by a health center are encouraged by the center to treat patients at a homeless program, and the activity is mentioned in the center's scope of project, but is not required (merely encouraged) by the center in its employee agreement, is the activity covered by FTCA?

    A: To be covered by FTCA, the activity must be in the health center's approved scope of project, and the activity must be outlined as a requirement in the provider's employment agreement.

13. Q: If a clinic employee provides services that are not funded by the PHS grant, but the service activity is included and described in the approved scope of project, is it covered by FTCA?

    A: Coverage is provided if the activity is part of the approved project, regardless of whether the activity is directly funded by PHS.

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14. Q: Are activities and services of volunteer staff covered if they are part of the health enters approved scope of Federal project?

    A: No. Volunteers are not covered under FTCA. Coverage is available only to officers, board members, employees and certain licensed or certified contractors (full-time or part-time providers of Family Practice, General Internal Medicine, General Pediatrics, and Obstetrics and Gynecology).

15. Q: How can I find out if a certain activity is covered under FTCA?

    A: The PHS published regulations on May 8, 1995, and a Federal Register Notice September 25, 1995, which clarified the FTCA coverage for certain types of health center activities. If a health center is unsure whether a certain activity falls within the scope of the example given in these documents, then the health center should send a written request to the director of BPHC for a determination of whether this activity is covered under FTCA.

16. Q: Since there is a choice of whether to participate in FTCA, how do I decide?

    A: A grantee should evaluate the financial and clinical impact of FTCA coverage on the practice. The assessment should be approached broadly. For example, a grantee may have a comprehensive insurance package that is less costly for the organization than having coverage with the FTCA and buying separate policies for other types of insurance. On the other hand, by coming under FTCA coverage, an organization may be able to establish more competitive capitation rates or fees, and add additional clinical or outreach services which in the past would have been financially impossible because of high malpractice costs.

17. Q: Do I need to re-apply to be "deemed" under the new FTCA?

    A: If you already have been deemed, you are covered now. However, the Bureau must re-determine eligibility for FTCA under the new law by June 23, 1996. Thus, in March 1996, the BPHC will issue guidance on the additonal information needed.

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18. Q: If a grantee is currently deemed eligible for FTCA coverage, can its current private malpractice coverage, be terminated?

A: Yes. A deemed grantee can rely on FTCA coverage in lieu of private malpractice coverage now.

19. Q: Is there a cost to the grantee for FTCA coverage?

A: No.

20. Q: My health center was deemed eligible for FTCA coverage on July 1, 1994, but we continued to keep our comprehensive private claims-made policies. We now want to drop our private insurance and use FTCA for malpractice. Do we need to purchase tail insurance for our providers?

A: FTCA is comparable to an occurrence type of malpractice policy, since both present and future claims are covered. Your private policies would only cover claims filed while the policies were in effect and provides no coverage for future claims. Therefore, after canceling your private insurance, you would still have FTCA in effect for any future claims for the period after the date of deeming and tail insurance is not needed for that period.

However, for health centers previously insured with claims-made policies tail insurance is advisable for any time period prior to the date of deeming for FTCA. For example, if Dr. John Doe was an employee of the deemed health center from July 1, 1992, then tail insurance would not be needed other than for the period July 1, 1992 until June 30, 1994. In addition, if the private malpractice policies covered activities that are not subject to FTCA coverage, then tail insurance may be needed to cover those activities.

21. Q: If the grantee currently has private "claims-made" malpractice insurance coverage, and faces additional (or higher) one-time costs to cancel that coverage and purchase prior acts (or tail) coverage, will BPHC provide one time supplemental funding to assist in meeting those costs?

A: BPHC does not have the resources to provide additional supplemental funding for such tail coverage. Since FTCA coverage provides significant future savings for most centers, many grantees have been able to spread tail cost over 2-3 years, thus avoiding high one-time costs. At least one State primary care association is exploring group purchase of tail coverage for all health centers in the State.

22. Q: If a grantee would realize a savings under the FTCA by canceling its private malpractice insurance, how much of the savings will be retained by the grantee?

A: The entire savings would remain at the grantee to be utilized for the provision of health services.

23. Q: I am currently deemed under the FTCA. Do I still need general liability insurance?

A: Yes. FTCA only covers medical and dental malpractice. Health centers need to purchase general liability insurance, including directors and officers insurance, etc.

24. Q: Several of my center's contracts with managed care plans require that I maintain private malpractice insurance coverage at certain dollar levels. What should I do?

A The new amendments contains a section that requires all managed care plans to accept FTCA coverage as meeting whatever malpractice coverage requirements they may have. Failure to do so could subject a plan to being barred from participating in Medicare and Medicaid for as long as the HHS Secretary determines appropriate (NOTE: current FTCA law has a similar provision regarding hospitals' acceptance of FTCA coverage).

25. Q: The new law defines a time line for the processing of a claim. What does that mean for a grantee?

A: More closely defined timelines ensure that legal procedures are completed on a timely basis which is important for all parties involved. It also means that health centers must respond to requests for information, such as medical records, in a timely manner.